

## **Equal Benefits Substantial Compliance Authorization Form**

Department of Executive Services Finance and Business Operations Division **Procurement and Contract Services Section** NCOB, MLK-ES-0340

NCOB, MLK-ES-0340 401 Fifth Avenue, 3rd Floor, Seattle, WA 98104 206-263-9400 TTY Relay: 711 Fax: 206-296-7676

Name	of	Contractor:	
Conta	ict F	Person:	Phone Number:
Fax:		E-mail	l:
Appro	xim	nate Number of Employees in the U.S.	Solicitation / Contract #:
entities benefits Section	s se s. A n (P	eking to enter into a contract with King County and contractor must have this form approved by Kip (CSS) prior to the award of the proposed contract.	submitted along with supporting documents by those and need additional time for implementation of equal ing County's Procurement and Contract Services act with King County. Upon approval, the form will be at to the Equal Benefits Compliance Declaration.
delay ir	n im		ized delay and related instructions. Authorization in a sidered by meeting one or more of the following
Γο con	tinu	ue the application process, choose ALL the cate	gories that apply:
_ c	olle	ective Bargaining Delay	
		ing discrimination in benefits may be delayed ur ective bargaining agreement(s) where all of the f	ntil the expiration of a County Contractor's current following conditions have been met:
1		The provision of benefits is governed by one o	r more collective bargaining agreement(s);
2	•	The County Contractor takes all reasonable m requesting that the Unions involved agree to re Contractor to take whatever steps necessary t discrimination in benefits without reopening the	to end discrimination in benefits OR by ending
3			t end discrimination in benefits despite taking all written proof of the efforts taken to seek the Union's
condition	ons		<b>oof</b> must be submitted with this form that the above County Contractors to provide to the Unions involved stract Services Section at 206-263-9400.
Name	of	the labor organization(s) and expiration date(s)	for each collective bargaining agreement:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
Please	list	t the benefits for which the delay is requested:	

Please describe efforts made to implement equal benefits for Collective Bargaining Delay:			
	Open Enrollment Delay		
	Implementation of equal benefits may be delayed unti- enrollment process following the date the contract with may not exceed twelve (12) months from the date the applies only to benefits for which an open enrollment	n the County begins. This open enrollment delay e contract with the County is entered into and	
Nex	t benefit plan year begins: Date Equal	Benefits will be available to employees:	
Des	scription of benefits that will be delayed and reason for d	elay:	
Des	scription of efforts being undertaken to implement equal	benefits for Open Enrollment Delay:	
	Administrative Delay		
	Implementation of equal benefits may be delayed to a nondiscriminatory benefits in the County Contractor's exceed three (3) months. An extension of this time m the written request of the Contractor. Administrative st actions as computer systems modifications, personne distribution of employee communications.	infrastructure. This administrative delay may not ay be granted at the discretion of the County, upon teps may include, but are not limited to, such	
Des	scription of benefit(s) that will be delayed:		
Des	scription of necessary administrative steps to implement	equal benefits, and dates to be achieved:	
	Cash Equivalent		
	In limited circumstances, the County may authorize a Cash Equivalent payment in lieu of benefits that are u contractor's control. The authorization does not relieve benefits it offers on an equal basis.	navailable due to circumstances outside of the	
	The County will evaluate each request to provide a Cadecisions will be based on a consideration of such factors.		
	The numbers of benefits providers identified and conta these providers that they will not provide equal benefit willing to offer equal benefits coverage to the contract	s coverage; and the existence of benefits providers	
Plea	ase provide the name(s) of the Contractor's current	benefit provider(s):	
Nan	me of Provider:	Phone:	
Con	ntact Person:	Benefit:	
Nan	ne of Provider:	Phone:	
	ntact Person:	Donafit	

I declare under penalty of perjury under the correct and true, and that I am authorized to Executed this day of, 20	laws of the State of Washington that the foregoing is bind this entity contractually.
I declare under penalty of perjury under the correct and true, and that I am authorized to	laws of the State of Washington that the foregoing is bind this entity contractually.
I declare under penalty of perjury under the correct and true, and that I am authorized to	laws of the State of Washington that the foregoing is bind this entity contractually.
Any additional information relevant to the contra	
Any additional information relevant to the contra	
Any additional information relevant to the contra	
Any additional information relevant to the contra	
	actor's enon to acquire Equal benefits coverage.
Contact Person:	
Name of Provider:	
Contact Person:	
Name of Provider:	
Contact Person:	
Name of Provider:	<u> </u>
Name of Provider: Contact Person:	Date: Phone:
Contact Person:	
Name of Provider:	
Providers contacted for the purpose of acqu	iring Equal Benefits coverage:
Contact Person:	Danie Ch
Name of Provider:	Phone:
Name of Provider:  Contact Person:	Donofite

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Address